

# ZIMBABWE AND HIV/AIDS

## Key Talking Points

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Zimbabwe has the highest HIV prevalence rate in Africa and one of the highest in the world.

- One in four adults is infected with HIV.
- Approximately 2,000 people acquire new HIV infections every week.
- Studies have found HIV prevalence rates of 70 to 86 percent among high-risk groups.

**AIDS Deaths** BUCEN estimates that more than 200 people die from AIDS each day. Life expectancy in 1998 was already down to 39 years, compared to just over 60 a decade ago.

**Women and HIV** BUCEN estimates that in 1997, 28 percent of pregnant women attending Harare urban antenatal clinics and 46 percent attending Beitbridge rural district clinics tested positive for HIV. Zimbabwean women successfully petitioned their government for access to female condoms, an HIV prevention method they can initiate themselves.

**Children and HIV** The epidemic is reversing years of progress in child survival. Fifteen percent of new AIDS cases are children under age 5.

**AIDS Orphans** The rising number of orphans is changing the social structure of the country. By 1998 an estimated 750,000 children had lost one or both parents to AIDS, with projections of nearly one million AIDS orphans by 2005.

**Socioeconomic Impact** Households will spend about \$23 million related to AIDS deaths in 1999. By 2005, 60 percent of Zimbabwe's health budget will be required for AIDS treatment alone. Seven out of ten AIDS cases occur in Zimbabweans during the most productive years of their lives—ages 20 to 49. A study of a major transport company found that HIV/AIDS costs totaled 20 percent of its profits in 1996.

**USAID** has supported HIV prevention activities since 1987. Although the mission was slated to close, in early 1999 it submitted a new strategy which would postpone the closeout date. An enhanced HIV/AIDS program is now being designed. USAID/Zimbabwe sponsored the first social marketing project for the female condom.

**National Response** Despite the magnitude of the epidemic, few people perceive themselves to be at risk. Denial and stigma encourage discrimination and weaken prevention efforts. Lack of strong government leadership has hampered HIV prevention efforts in the past. However, there are signs that the leadership is becoming more responsive. In 1998 Parliament passed a law requiring all companies to institute HIV/AIDS programs. And in his 1999 Independence Day speech, the president announced that a National AIDS council would be established in the President's Office.

**Further progress** requires strong commitment from Zimbabwe's leadership and an NACP with authority to lead the country's response to HIV/AIDS.



**U.S. Agency for  
International Development  
Population, Health and Nutrition  
Programs  
HIV/AIDS Division**

1300 Pennsylvania Ave., N.W.  
Ronald Reagan Building, 3<sup>rd</sup> Floor  
Washington DC 20523-3600  
Tel: (202) 712-4120  
Fax: (202) 216-3046  
URL: [www.info.usaid.gov/pop\\_health](http://www.info.usaid.gov/pop_health)



**Implementing AIDS Prevention  
and Care (IMPACT) Project**

Family Health International  
2101 Wilson Boulevard, Suite 700  
Arlington VA 22201 USA  
Telephone: (703) 516-9779  
Fax: (703) 516-9781  
URL: [www.fhi.org](http://www.fhi.org)

# ZIMBABWE AND HIV/AIDS

## Country Profile

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Zimbabwe is the second most developed country in southern Africa. With an abundance of natural resources and a sophisticated infrastructure, Zimbabwe plays a central role in regional economic and political stability. But recent development challenges, including a public sector financial crisis and deepening poverty, threaten to reverse the country's socioeconomic progress.

The Zimbabwean government made the health sector a priority in the post-independence 1980s, and a substantial infrastructure was developed. The World Bank has observed that preventive maternal and child health practices have been impressive since 1988. For example, in 1994, 69

percent of women gave birth in a medical facility and 68 percent of children were fully immunized.

With reduced human and financial resources and greater stress placed on the system by HIV/AIDS, however, Zimbabweans' health has begun to deteriorate. The 1997 intercensal survey reported that childhood mortality increased by 39 percent and infant mortality by 21 percent between 1992 and 1997. Tuberculosis (TB), malaria, and sexually transmitted infections (STIs) are widespread. According to the World Bank, the country's HIV/AIDS and TB epidemics are a national emergency.

## *HIV/AIDS in Zimbabwe*

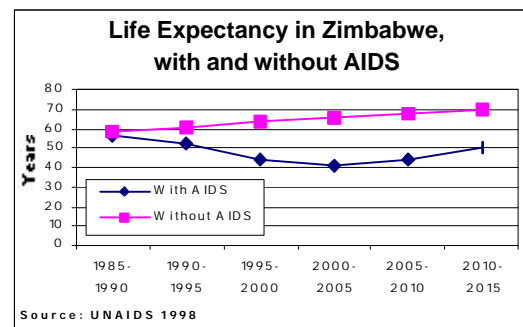
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Zimbabwe has the highest HIV prevalence rate in Africa and one of the highest in the world.

- One in four adults is infected with HIV.
- An estimated 1.6 million of Zimbabwe's population of 12.5 million are living with HIV.
- In 1997 approximately 2,000 people acquired new HIV infections every week.

As a result of HIV/AIDS, the crude death rate in Zimbabwe will be more than 200 percent higher in 2005 than it was in 1990.

- About 70,000 Zimbabweans are expected to die from AIDS-related diseases in 1999—twice as many as in 1998.
- More than 200 people die from AIDS each day.
- Life expectancy in 1998 declined to 39 years, compared to just over 60 years a decade ago.



Despite these grim statistics, there has been a national code of silence about HIV/AIDS. Relatives express relief that the deceased has mercifully "passed away." The media lament the shocking and sudden passing away of an illustrious personality. Rarely is AIDS acknowledged as the cause of death.

## ZIMBABWE AND HIV/AIDS

### *HIV/AIDS and Women*

Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection.

- In 1997, 28 percent of pregnant women attending Harare urban antenatal clinics and 46 percent attending Beitbridge rural district clinics tested positive for HIV.
- The number of AIDS cases among women peak in the 20- to 29-year-old range, the prime reproductive and parenting years.

Male and female mortality rates are approximately equal until age 30, after which male mortality exceeds female mortality by 26 percent.

Zimbabwe was the first country in Africa to introduce the female condom. It was approved for wide use after a petition, drafted by women's advocacy groups and signed by about 20,000 individuals, was presented to the Ministry of Health. The female condom is now available through both social marketing programs and in public clinics.

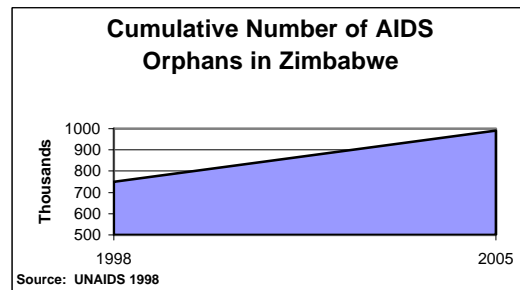
### *Children and HIV/AIDS*

Fifteen percent of new AIDS cases are children under age 5. The Zimbabwean government is now conducting pilot studies on the effectiveness of antiretroviral treatment in reducing mother-to-child transmission. However, at present the cost of expanding this nationwide is very expensive, given the government's limited resources.

HIV/AIDS also jeopardizes the future of uninfected children. When an adult dies, many families can no longer afford school fees. Girls are taken out of school to assist with care giving and boys are taken out to earn money. This deprives them of opportunities to gain important skills

By 1998 an estimated 750,000 children in Zimbabwe had lost one or both parents to AIDS,

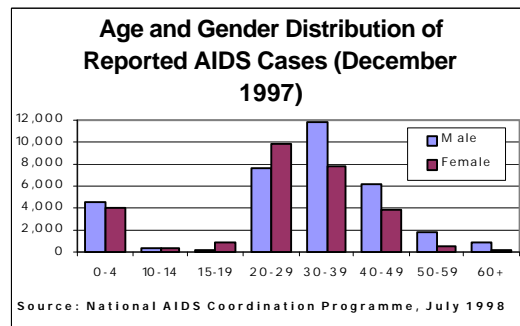
with projections of nearly 1 million AIDS orphans by 2005. The rising number of orphans is changing the social structure of the country. When extended families can no longer support them, adolescents often assume responsibility for their siblings and households.



### *Youth and HIV/AIDS*

According to police, court officials, social workers, and women's rights activists, an increase in rapes of young African girls is becoming a significant cause of HIV/AIDS in children. Some men believe that sex with virgins can bring magical powers and possibly cure AIDS, and some traditional herbal or spiritual practitioners are even prescribing this remedy for HIV-positive patients. In response to this problem, the 50,000-member Zimbabwe National Traditional Healers Association is holding workshops to improve healers' understanding of HIV/AIDS and clarify treatment misconceptions.

In the 15- to 19-year-old age group, more than five times as many young women as young men are reported to be HIV-positive. This is due partly to the physiological immaturity of the young female reproductive system, and partly to the early age of



## ZIMBABWE AND HIV/AIDS

onset of sexual activity among girls. The age and gender distribution of AIDS cases in Zimbabwe

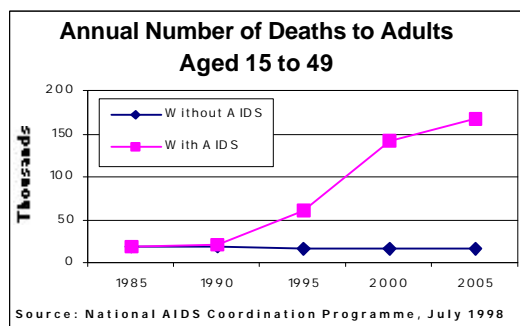
shows that much of the HIV transmission occurs from older men to younger women.

### Socioeconomic Effects of HIV/AIDS

The illness and death caused by HIV/AIDS have significant social and economic effects on Zimbabwean families. The Community Working Group on Health estimates that in 1999 households will spend \$23 million related to AIDS deaths alone. Many households will deplete their resources caring for the sick and dying, coping with funeral expenses, and compensating for lost labor and income. Traditional social and care support mechanisms are rapidly breaking down, especially in urban areas. Families unable to meet their own needs and obligations are now reluctant to support members of their extended families.

Already weakened by drought, food security is jeopardized by AIDS-related reductions in the labor force and rural household savings. Households are forced to plant less labor-intensive crops, resulting in a 61 percent loss in rural production. A study by The Zimbabwe Farmers Union (ZFU) showed that the death of a breadwinner due to AIDS has a much greater impact on crop production in small-scale farming and communal areas than does a non-AIDS death, as shown in the following table.

Crop	Percentage loss in production	
	With AIDS death	With non-AIDS death
Maize	61	45
Cotton	47	20
Vegetables	49	21
Groundnuts	37	0



At the national level, a diminished, skilled labor pool affects economic prosperity, foreign investment, and sustainable development. Seven out of ten AIDS cases occur among those in the most productive stage of their lives—adults ages 20 to 49.

The costs of training new workers, lost productivity, and absenteeism due to HIV/AIDS are taking their toll on the nation's industries. According to the World Bank, HIV ranks second among all diseases in loss of productive years in Zimbabwe.

The impact of HIV/AIDS on industry is reflected in the example of a major transport company with 11,500 workers. A study found that more than 3,400 employees were HIV-positive in 1996, with 64 AIDS-related deaths. The company's total HIV/AIDS costs were more than \$1 million, or 20 percent of the company's profits. Health care costs accounted for half the loss in profits. By 2005 the cost of HIV/AIDS to the company could reach \$2.8 million.

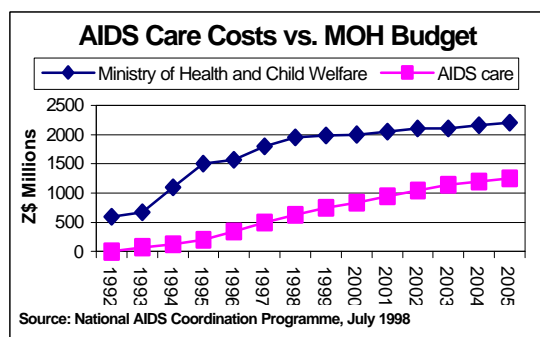
HIV/AIDS costs threaten to overwhelm a health sector that faces severe budget cutbacks and consequently is overloaded and understaffed. Only 75 percent of public posts for nurses and 36 percent for doctors are filled. The erosion of real wages in the public sector and increases in deaths

*Insurers attempt to protect their businesses from such losses by charging more or refusing policies to HIV-positive customers. Life insurance premiums in Zimbabwe quadrupled in two years because of HIV/AIDS.*

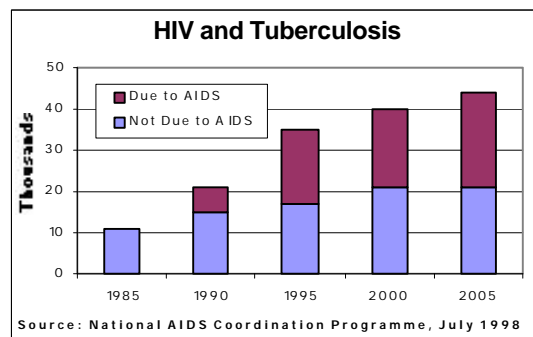
## ZIMBABWE AND HIV/AIDS

and workloads due to AIDS have contributed to increases in turnover and low morale.

Treating each AIDS case in Zimbabwe costs over \$1,000. By 2005, 60 percent of the budget of the Ministry of Health and Child Welfare will be required for AIDS treatment alone, excluding antiretroviral therapy.



A TB epidemic fueled by HIV/AIDS will further strain health care resources. Reported TB cases increased fivefold from 1995 to 1998, and two-thirds of new cases were in HIV-positive individuals. The Ministry of Health projects that the proportion of the population developing TB every year will approach 3.2 percent, or an additional 23,000 cases, by 2005.



## Interventions

### *The National Response*

The first AIDS cases were reported in Zimbabwe in 1985. Soon afterward, the government established the National AIDS Coordination Program (NACP), housed in the Ministry of Health, to coordinate national prevention efforts and donor-supported activities.

The Second Medium Term Plan (MPT2) called for the following activities, mostly funded by external donors, for 1994-1998:

- Preventing transmission of HIV and other STIs through information, education, and communication (IEC), counseling, promotion of condom use, and early diagnosis and treatment of STIs.
- Providing health care, counseling, and social services for people living with HIV/AIDS (PLWHA) and their families to reduce the personal and social impact of HIV/AIDS and STIs.
- Reducing the impact of HIV/AIDS and STIs on labor supply and public expenditures.

However, the national effort lacked commitment from senior officials. Most activities were actually

carried out by private voluntary organizations (PVOs) and nongovernmental organizations (NGOs).

In 1998 the NACP proposed the Medium Term Plan 3 for 1999-2004. Building on MPT2 activities, the plan calls for a multisectoral response; an HIV/AIDS coordination and management framework; improvements in the social, economic, and cultural status of women; and reduced discrimination against PLWHA. The NACP acknowledges the need to mobilize strong commitment from the government and continued and increasing support from NGOs and community-based organizations (CBOs), the community, the private sector, and churches.

In 1998 there were welcome signs of progress in gaining leadership support. A new energy and focus on HIV/AIDS apparently resulted from a policy study tour taken by senior officials to observe Uganda's successful HIV/AIDS prevention strategy. In his December State of the Union Address, President Mugabe acknowledged that HIV/AIDS was threatening economic growth and stability, and called for nationwide commitment and effort in HIV/AIDS prevention.

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*The world's first national launch of the female condom has become a model for other African countries. Through a petition signed by 20,000 individuals, women in Zimbabwe demanded that the Ministry of Health register and make female condoms available for self-protection.*

Parliament passed a law requiring all companies to institute HIV/AIDS programs or pay penalties.

Current antiretroviral treatments are too expensive for national use. However, a two-year pilot project to reduce mother-to-child transmission (MTCT), funded by UNAIDS and UNICEF, will provide counseling, testing, and treatment with short-course AZT therapy for pregnant women in three urban clinics. Modification of the national infant feeding policy will include counseling on such issues as the risk of postnatal HIV transmission via breastfeeding.

The Ministry of Health-integrated and comprehensive program for STI prevention and care, funded by the World Bank, makes condoms available to complement information, education, and communication (IEC) efforts; trains provincial and district health workers in syndromic management of STIs; and provides appropriate drugs for STI treatment.

The NACP, funded by USAID and in collaboration with Population Services International and Family Health International, is introducing social marketing of voluntary HIV counseling and testing (VCT) services. Starting with three sites, in April 1999 a network of new centers will be established in a variety of existing facilities to provide affordable, accessible, and appealing services.

In addition to the government public social welfare system, Zimbabwe has widespread grassroots services providing care and support to PLWHA and their families. More than 100 church and women's groups, CBOs, and PLWHA organizations have responded to the overwhelming need for assistance.

According to the Deputy Minister of Health and Child Welfare, the country is working in conjunction with the Zimbabwe Traditional Healers Association to improve education in HIV/AIDS prevention and the use of herbal drugs to treat HIV/AIDS symptoms. The association's full-time staff and volunteers teach traditional healers about HIV/AIDS and STI prevention, education, and counseling; counseling for PLWHA; condom distribution; and working with community leaders for the care and support of orphans.

### Donors

Multilateral and bilateral donors are actively engaged in Zimbabwe. According to a UNAIDS/Harvard University study, each bilateral

organization contributed the following amounts in 1996-97.

Donor	US\$ Amount 1996-1997
DFID	8,656,000
USAID	5,010,000
DANIDA	2,284,407
Netherlands	1,952,000
AUSAID	1,785,213
Canada	1,618,000
Norway	967,214
Others	530,725
EU	30,992
<b>Total</b>	<b>22,834,551</b>

*Bilateral organization contributions 1996-1999*

## ZIMBABWE AND HIV/AIDS

FHI efforts to sensitize business owners and managers to the need for HIV prevention services led some to assume ownership of projects. For example, the National Employment Council for the Transport Operating Industries (NECTOI) leveraged funds and trucks for condom distribution from trucking companies and provided or contributed to transport, per diem, office support, and yearly salary increases for project staff.

**USAID's** funding request for family planning and HIV/AIDS in FY 1999 was \$2,550,000, compared to \$1,950,000 in FY1998. The mission was slated for closeout in 2003, but this date has been extended. (USAID recently submitted a new strategy to USAID/Washington for approval.) As the HIV/AIDS epidemic worsened in Zimbabwe, the mission shifted in 1998 from a peer education strategy to one emphasizing voluntary counseling and testing services. USAID also supports the development and dissemination of a comprehensive national HIV/AIDS policy, and technical assistance for a communication strategy to move HIV/AIDS higher on the national development agenda.

Activities are implemented through local NGOs and international agencies as well as cooperating agencies, including Family Health International, The Futures Group, PACT, and Population Services International. HIV/AIDS activities have included the following:

- Promoting improved HIV/AIDS policies by providing decision makers with training in the use of the AIDS Impact Model developed by The Futures Group.

- Increasing male condom availability through PSI's social marketing project (co-financed with DFID).
- Providing a socially-marketed female condom demanded by Zimbabwean women.
- Strengthening NGO capacity to provide improved, expanded, and sustainable HIV/AIDS prevention and counseling services through a five-year project implemented by PACT.
- Increasing positive behavior change and sexual responsibility through interventions implemented by FHI among women, youth, and selected occupational groups (uniformed services, commercial farmers, university students, and factory and transportation workers).
- Supporting education in tertiary institutes such as teachers training colleagues through a grant to Unicef.
- Enhancing the capacity of public institutions, NGOs, and CBOs to design and implement effective programs for orphans and other groups affected by the HIV/AIDS crisis.

**The World Bank's** HIV/AIDS-related activities include developing the management and administrative capabilities of the NACP and financing condoms, STI drugs and diagnostic tests, drugs to treat TB and other opportunistic infections, tests and supplies for HIV diagnosis and blood screening, and protective supplies for health care workers.

**UNAIDS'** theme group in Zimbabwe is called the UNAIDS Steering Committee. Chaired by a resident coordinator, it includes representatives from UNDP, WHO, UNFPA, UNICEF, the World Bank, and UNIFEM. Support from these UNAIDS cosponsors in 1996-1997 included the following:

Donor	Amount US\$ 1996-1997
UNICEF	3,755,200
World Bank	2,120,000
UNAIDS	964,627
WHO	50,000
UNFPA	40,000
UNESCO	36,190
<b>Total</b>	<b>6,966,017</b>

*UNAIDS cosponsor support 1996-1999*



## ZIMBABWE AND HIV/AIDS

UNAIDS priority strategy involves improved HIV/AIDS IEC. Contributions for 1998-99 totaled \$367,250. From 1998 to the year 2000, UNAIDS

is providing \$736,000 for pilot studies on AZT short-course therapy for MTCT.

### ***Private Voluntary Organizations (PVOs), Nongovernmental Organizations (NGOs) and Research Institutions***

A number of PVOs implement activities funded by multilateral and bilateral donors. NGOs also receive funding from a variety of sources. Most NGOs working in HIV/AIDS were registered fairly recently and lack institutional history or long-term experience. The NGO AIDS Consortium assists in organizing their efforts. *See attached preliminary chart for PVO, USAID cooperating agencies, and NGO target areas of HIV/AIDS activities. This list is evolving and changes periodically.*

The University of Zimbabwe, in collaboration with Stanford University School of Medicine and the University of California San Francisco, serves

as the research site for the HIV Network for Prevention Trials (HIVNET). HIVNET was established in 1993 by the U.S. National Institute of Allergies and Infectious Disease (NIAID) to conduct trials of promising HIV prevention strategies in the United States and abroad. Research areas include HIV preventive vaccines; topical microbicides; STI treatment; MTCT prevention; hormonal contraception and HIV; and behavioral risk-reduction strategies. In 1998 the Harare site hosted a regional workshop on community participation in HIV/AIDS prevention research.

## Challenges

Major constraints to HIV/AIDS control in Zimbabwe include:

- The small percentage of people who perceive themselves at high risk for HIV/AIDS.
- The entrenched stigma of being HIV-positive.
- Lack of government leadership and commitment in responding to the pandemic.
- The NACP's reliance on donor funding. NACP staff are almost entirely donor supported, and their numbers fluctuate with project end dates and funding levels.
- Shortage of clinic staff and inadequate training in STI/HIV/AIDS management and HIV/AIDS counseling.
- The public health sector is facing a crisis as resources have declined at the same time as health needs have increased.

- Inadequate access to comprehensive community-based care and referrals for PLWHA.

The following gaps must be filled in order to mount an effective response to HIV/AIDS in Zimbabwe:

- Political leadership and commitment from the top level.
- A government agency with authority to lead and coordinate the response to the epidemic.
- A multisectoral approach.
- An effective sentinel surveillance system.
- Accessible and affordable VCT programs.
- Relief from the disproportionate burden of HIV/AIDS on women and girls.
- A policy on how to deal with the orphan crisis.

## The Future

Seventy-five percent of the population are not infected, and the vast majority of children ages 5

to 14 are free from HIV. They can still be protected.



## **ZIMBABWE AND HIV/AIDS**

Much depends on visible commitment from the country's leadership. Public endorsements and supportive action by national and community leaders will heighten awareness of the threat posed by the epidemic, and promote a multisectoral response to HIV/AIDS at every level of society.

With senior-level commitment, an effective surveillance system, a comprehensive national strategy, and intensive prevention and care programming at all levels, progress could be made in fighting the HIV/AIDS pandemic.

### **Important Links and Contacts**

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1. The National AIDS and Coordination Program, Causeway, Harare: Tel: 263-4-702446/792981
2. Zimbabwe AIDS Network, Box CY 3006, Causeway, Harare: Tel: 721010



**U.S. Agency for  
International Development  
Population, Health and Nutrition  
Programs  
HIV/AIDS Division**  
1300 Pennsylvania Ave., N.W.  
Ronald Reagan Building, 3<sup>rd</sup> Floor  
Washington DC 20523-3600  
Tel: (202) 712-4120  
Fax: (202) 216-3046  
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Family Health International  
2101 Wilson Boulevard, Suite 700  
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April 1999

**U.S. Based  
Institutional Interventions**

# Zimbabwe

<b>Organization</b>	<b>Intervention</b>																
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC	MTCT	Research	Policy	STD	VCT	Orphan	TB	Other

## Cooperating Agencies

CAPS - UCSF											X						
Futures Group	X																
John Hopkins University											X						
PACT																	NGO Capac.
Population Services Int.					X									X			
Pop. Council/Horizons					X		X				X		X	X			

## PVOs/NGOs

Civil/Military Alliance to Combat HIV/AIDS	X			X					X								
Lutheran World Relief									X								
MacFarlane Burnet Centre			X	X			X		X	X	X	X		X	X		
Media for Development International									X						X		
Medical Mission Sisters																	
Salvation Army	X	X	X	X	X		X		X			X	X	X	X	X	

<b>KEY:</b>	<b>Advoc.</b>	Advocacy	<b>MTCT</b>	Mother to Child Transmission activities
	<b>BCI</b>	Behavior Change Intervention	<b>Research</b>	HIV/AIDS research activities
	<b>Care/S</b>	Care & Support Activities	<b>Policy</b>	Policy monitoring or development
	<b>Training</b>	HIV/AIDS training programs	<b>STD</b>	STD services or drug distribution
	<b>Cond.</b>	Condom Distribution	<b>VCT</b>	Voluntary counseling and testing
	<b>SM</b>	Social Marketing	<b>Orphan</b>	AIDS orphan activities
	<b>Eval.</b>	Evaluation of several projects	<b>TB</b>	TB control
	<b>HR</b>	Human Rights activities	<b>Other</b>	(I.e. blood supply, etc.).
	<b>IEC</b>	Information, education, communication activities		